RIGHTS

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PRINTED. 12/07/2007

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLA STATEMENT OF DEFICIENCIES COMPLLYED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING CA. WING 11/29/2007 09@159 STREET ADDRESS, CITY, STATE, ZIP GODE NAME OF PROVIDER OR SUPPLIER 6613 6TH STREET, NW CAREÇO 02 WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 000 W 000 INITIAL COMMENTS A follow-up to the initial survey which was completed on 4/13/2007 was conducted on 11/28/2007 after the facility submitted a Plan of Correction which alleged compliance on 5/10/2007. Observation, staff and interview and a review of the facility 's presented plans of correction revealed the provider failed to enact and enforce the necessary measures required to abate the deficiencies cited below. W 124 W 124 483,420(a)(2) PROTECTION OF CLIENTS

The facility must ensure the rights of all clients. Therefore the facility must inform each client, perent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the
facility continues to be without the services of a
legal guardian to insure the proper and necessary
communication as required by this section. (Client
#3)

The finding includes: On 4/13/2007 the state agency conducted this facility's annual recertification and cited that "no system had been established to provide

guardianship for consent or legally sanctioned advocacy "for Client #3. The provider submitted their plan of correction and indicated that this deficiency would be resolved by 5/31/2007. The state agency conducted a monitoring visit on 11/28/2007 and found that Client #3 was still without the services of any legally sanctioned

W124

The QMRP has submitted a request for guardianship to the Dept of Disability Services per agency and DDS policy. To date a hearing date has not been assigned. The QMRP will make monthly follow up calls to determine status and document in the monthly reviews.

12/31/07

LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

TAG (BX)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event JO: C8YS11

Facility ID: 09G159

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HKA 2005 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/07/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 8. WING 096159 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 02 6613 GI'H STREET, NW WASHINGTON, DC 20012 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 124 Continued From page 1 W 124 advocate. The facility 's Qualified Mental Retardation Professional (QMRP) was interviewed on 11/28/2007 at 3:17pm and she indicated that a request for guardianship had been submitted to the courts on behalf of this client, but as of the date of the monitoring, no guardian had been assigned. W 189 l 483.430(e)(1) STAFF TRAINING PROGRAM W 189 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure staff received the proper and necessary training to ensure client privacy; The findings include: 1. On 4/13/2007 the state agency conducted this facility 's annual recertification and found the facility 's practices to be deficient in the area of client privacy (W130). The provider submitted their plan of correction and indicated that the QMRP would ensure the facility 's staff received further in-service training on the rights-of-residents and on how to assist them in observing privacy by 5/31/2007. This proactive measure was to be employed as a means of ensuring that the clients as well as the facility 's staff would better understand how to ensure and manage a client's privacy. At 3:23pm during the

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state agency 's monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/21/2007 for staff training on "appropriate clothing (for modesty), bathing, dressing, and grooming ". Of the twelve staff presently on the

current work schedule, only two was in

Event ID: C8YS11

Facility ID: 08G158

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| DEPAR CENTE | RS FOR MEDICARE | AND HUMAN SERVICES MEDICAID SERVICES | | | FORM |); 12/07/200° /IAPPROVEI |
|---------------------------|---|--|---------------------|--|---|------------------------------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/GLA IDENTIFICATION NUMBER: | A. BUILDIN | | (X3) DATE S | <u>), 0938-039</u> SURVEY |
| NAME OF | | 09G159 | B. WING | | 11/: | 2 9 /2007 |
| CAREC | PROVIDER OR SUPPLIER D 02 | | 66 | EET ADDRESS, CITY, STATE, ZIP CO 613 6TH STREET, NW /ASHINGTON, DC 20012 | | |
| (X4) (D) PREFIX TAG | 1 (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX YAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X3) COMPLETION DATE |
| | attendance and signature was no evide survey to substantial that its staff receive training to maintain 2. On 4/13/2007 the facility is annual received training to mainted in indicated that if all simplementing incides on 5/10/2007. In addicated that if the apolicy on holding income include terminal occurrences. At 3 agency is monitoring QMRP presented a 9/11/2007 for staff to Reporting income and signature was no evider survey to substantial that its staff received training to maintain a linjuries of unknown of 3. On 4/13/2007 the facility is annual received facility is practices to implementing a client (BSP) (W193 & W24 their plan of correction following: a. For Citation #1 to a supports for Client #2 ndicated that its Staff | ned for the 5/21 training. Ince on file at the time of atte that the facility ensured of the proper and necessary and manage client privacy. In state agency conducted this certification and found the to be deficient in the area of unknown origin (W153). The their plan of correction and interpretation, the facility enforce its lividuals accountable, which alon for failure to report such 37pm during the state g visit on 11/28/2007, the sign-in sheet that was dated alning on "Incident twelve staff presently on the le, only two was in ed for the 9/11 training. Ince on file at the time of the that the facility ensured the proper and necessary and manage the reporting of origin. In the proper and found the area of the behavior support plan sheating and indicated the address the behavioral the facility's response | W 189 | I. Training on privaddressed in the training on Residents. This occurrent upon deployment facility and annuthereafter. Copied documentation with agency's main and a service within 3 deployment of the actual training and a service within 3 deployment. Such trainings will be documented on the Employee Checklifiled at the facility 3 days of the actual training. | agency's dent's curs at cation, t to a ally es of vill be ry and at n office, ning led in the able for ays of g. SP's 7 and loyees al | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED .

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING B. WING 096159 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW **CAREÇO 02** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 189 Continued From page 3 W 189 March 9 2007, A second session was scheduled for those who missed the first offering. In addition, all staff [is] trained on behavior management prior to or upon deployment into the home ... All staff has been retrained on implementation of all BSP's including the one developed for Client #2. Staff will not be assigned to support clients until they have a fundamental understanding of the BSP. This acknowledgement will be documented. At 3:40pm during the state agency 's monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on "Behavlor Support Plans " . Of the twelve staff presently on the current work schedule, only one was in attendence and signed for the 9/11 training. There was no evidence on file at the time of b. In addition to training survey to substantiate that the facility ensured that its staff received the proper and necessary on BSP's, staff received training to maintain and manage the additional training on implementation of a client 's behavior Active Treatment, which management plan. b. For Citation #2 to address the behavioral is a proactive measure of supports for Client #3, the facility 's response Client #3's behavior indicated that " Staff will receive additional training on implementing the active treatment management. routine for client #3 to properly support her in Documentation of these managing behavior. " In addition, the facility trainings will be further alleges that " the staffing patterns will be maintained at the facility reviewed with the governing body to determine how best to support Client #3 's [behavioral within 3 days of the needs]. " At 3:40pm during the state agency 's actual training. monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/2z/2007 for staff training on "Behavior Support 12/31/07 Plans " . Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. In

FORM CMS-2567(02-99) Previous Versions Obsolete

addition, the QMRP was interviewed on

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | ~ | | ···· | <u>OMB NO.</u> | <u>. 093</u> 8-0391 |
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| | | | A. BU | LDIN | | | Ç |
| | | 09G159 | B. WII | ۷G | | I . | 9/2007 |
| NAME OF F | PROVIDER OR SUPPLIER | | h , <u>,</u> | STR | REET ADDRESS, CITY, STATE, ZIP CODE | 1 1/4 | 0/2001 |
| CARECO | 0 02 | | | 66 | 613 6TH STREET, NW VASHINGTON, DC 20012 | | ; ; |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (XS) COMPLETION CATE |
| W 189 | 11/28/2007 at 3:45 the staffing pattern address this issue, more training was taddressing this clie evidence on file at substantiate that the meeting with the goits staff received the training to maintain implementation of a management plan. | pm and she indicated "that (s) were not changed to but the team decided that o be the best means of int's needs. "There was no the time of survey to e facility conducted the everning body or ensured that e proper and necessary and manage the | | 263 | | | |
| | are conducted only | uld insure that these programs with the written informed t, parents (if the client is a dian. | | | W263 Cross reference response for W124 | . | |
| | Based on staff inter facility failed to ensuinformed consent primedications and see The finding includes On 4/13/2007 the siffacility 's annual recfacility 's practices garnering parental option to implementing medications (W263 plan of correction and deficiency would be state agency conductively 28/2007 and four without the services | view and record review the use the provisions of a written rior to the use of psychotropic dation on a client. [Client #3] is tate agency conducted this certification and found the to be deficient in the area of or legally sanctioned consenting the use of psychotropic.). The provider submitted their and indicated that this resolved by 5/31/2007. The cted a monitoring visit on and that Client #3 was still of a legally sanctioned by 's Qualified Mental | | | | | |

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: C8YS11

Facility ID: 09G159

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | <u></u> |
|--------------------------|--|--|--|--|---|------------|
| | | 09G159 | Description numbers Option 199 Option 199 Option 199 Street Address, City, State, Zip Code estatement of Complete to Compl | i ' | | |
| NAME OF F | PROVIDER OR SUPPLIER D 02 | | 661 | 3 6TH STREET, NW | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI | HOULD BE COMPLETI | ION |
| W 263 | Retardation Profes interviewed on 11// indicated that a rec been submitted to client, but as of the | age 5 sional (QMRP) was 28/2007 at 3:17pm and she quest for guardianship had the courts on behalf of this date of the monitoring, no assigned. [Reference Citation | W 263 | | | |
| W 418 | \ | LIENT BEDROOMS rovide each client with a clean, as. | W 418 | - - | | |
| | Based on observat facility failed to ensimattress for one of facility. [Client #1] The finding include During the environr 11/28/2007 monitor was found to be un. The bed springs cobedspread and the excessively on the the room. The facility on 11/28/2007 at 4: was not aware Clientock note of the defevidence presented to substantiate that necessary measure this deficient practic 483,470(i)(1) EVAC | nental inspection on the ring visit, Client #1 's mattress even and lumpy to the touch. uld be felt through the edge of the mattress sloped side away facing the middle of ty 's QMRP was interviewed 48pm and she indicated she at #1 's mattress was bad and iciency. There was no if or on file at the time of survey the facility employed the is to prevent the recurrence of the call t | W 440 | The mattress will be rep the future, mattress insp will occur, minimally, of quarterly Internal Envir Care Surveys. Mattress unacceptable condition | ections luring onment of ses of will be | |
| RM CMS-256 | 37(02-98) Previous Varsions | Obsolete Event ID: C8Y\$11 | Facility | ID: 09G150 If c | ontinuation sheet Page 6 of | _ f 3 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2007 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATELS COMPL | |
|--|---|--|----------------------------|--|--|----------------------------|
| | | 09 G 159 | B. WING | | 11/2 | C 29/2007 |
| NAME OF PROVIDER OR SUPPLIER CARECO 02 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 440 Continued From page 6 This STANDARD is not met as evidenced by: Based on staff interview and record review, t the facility failed to ensure that evacuation drills occurred quarterly for all shifts. The finding includes: On 4/13/2007 the state agency conducted this facility's practices to be deficient in the area of conducting fire drills (W440). The provider submitted their plan of correction and indicated that "the Residential Director will review the evacuation drills minimally every quarter to ensure that each shift has the minimum amount of practice drills. Reviews will be documented and any problems noted in the drills will be immediately reported to the QMRP." This actio was to be effective and resolved by 5/31/2007. The facility's Work shifts are as presented below: 1. Weekday shifts: 7-3pm, 3-11pm, and 11-7am. 2. Weekend shifts: Same general shifts as above, but includes an overlapping 11-9am shift. The state agency conducted a monitoring visit on 11/28/2007 and found the following fire drills on record: 1. 04/06/07 7:00am 2Minuets 5Sec | 86 | EET ADDRESS, CITY, STATE, ZIP C 13 6TH STREET, NW ASHINGTON, DC 20012 | | | | |
| PREMX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | ID Prefix Tag | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| | This STANDARD Based on staff int facility failed to en occurred quarter! The finding include On 4/13/2007 the facility 's annual r facility 's annual r facility 's practice conducting fire dr submitted their pla that " the Resider evacuation drills r ensure that each of practice drills, and any problems immediately report was to be effective The facility 's QM 11/28/2007 at 3:5 facility 's work shi 1. Weekday shift 7am. 2. Weekend shift above, but include The state agency 11/28/2007 and for record: 1. 04/06/07 7:00 | is not met as evidenced by: erview and record review, t the isure that evacuation drills / for all shifts. es: state agency conducted this ecertification and found the s to be deficient in the area of ills (W440). The provider an of correction and indicated initial Director will review the ininimally every quarter to shift has the minimum amount Reviews will be documented inoted in the drills will be ted to the QMRP. " This action e and resolved by 5/31/2007. RP was interviewed on form and she confirmed that the fits are as presented below: is: 7-3pm, 3-11pm, and 11- its: Same general shifts as is an overlapping 11-9am shift. conducted a monitoring visit on und the following fire drills on am 2Minutes 5Sec orm 3Minutes 10Sec am 5Minutes 7 5Minutes | W 440 | W440 The Residential Director retrained on the protocol ensuring that fire drills completed and reviewe agency policy. Additionally will be inspected Internal Environment of Surveys. | ol for are d per onally, fire during | |

Event ID; C8YS11

Facility ID: 09G159

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Dec. 20 2007 12:24AM P10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/07/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED \sim B. WING 09G159 <u>11/29/2007</u> NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6813 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FUL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY W 440 Continued From page 7 W 440 7. 8/17/07 8:00pm 5min 8. Fire Drill filed but it does not have date, hour completed or total evacuation minutes.* 9. 10/17/07 8:30pm 4min 10. 10/31/07 5:00pm 2min *Document indicates the fire drill was conducted by Staff " A.G. " As documented, only one fire drill was held in the months of March and June of 2007; No fire drills were conducted on May or September of this year, Two shifts recorded having drills in August and October of 2007; and there was no evidence that the Residential Director had reviewed or ensured that " each shift had the minimum amount of practice drills " as stipulated in the Plan of Correction There was no evidence on file or presented at the time of survey to substantiate that the facility ensured the proper and necessary management of fire drills as required by this section. W 455 483,470(I)(1) INFECTION CONTROL W 455 There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that staff received the proper and necessary training to manage infection controls in a closed environment. The findings include: On 4/13/2007 the state agency conducted this

facility 's annual recertification and found the

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| DEPARTMENT | OF HEALTH AND HUMAN SERVICES |
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| STATEMEN AND PLAN (| f of deficiencies of correction | (X1) FROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE S COMPL | |
|------------------------|--|---|--------------|---|---|----------------------------|
| | | 09G159 | | *(m(i | 40.0 | C |
| | NAME OF PROVIDER OR SUPPLIER CARECO 02 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 455 Continued From page 8 facility 's practices to be deficient in the area of implementing infection control procedures to prevent the spread of communicable diseases. The provider submitted their plan of correction and indicated that "staff will receive additional training on infectious controls by the Director of Nursing". This action was to be affective and resolved by 5/31/2007. The facility 's QMRP was interviewed on 11/29/2007 at 4/26pm and she stated that there have been several changes in the organizational structure of the agency and that she was not aware of who currently held the title and position of Director of Nursing. In addition, she pointed out that the training had not been completed There was no evidence presented or on file at the time of survey to substantiate that the Director of Nursing at the facility. A BUILDING B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012 W 455 PREVIX (RACH CORRECTIVE ACTION SHI CROSS-REPERENCED TO THE APP DEFICIENCY) W 455 W 455 During the monitoring sur the QMRP noted that she believe the agency employed an "RN Supervisor". A training was conducted by the previous Supervisor who retained the documentation. Such evide will be obtained and maint at the facility. | | | 29/2007 | | |
| PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PŘEFIX | PROVIDER'S PLAN OF CO (FACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | N SHOULD BE | (XF) COMPLETION DATE |
| | facility 's practices implementing infection prevent the spread The provider submand indicated that training on infection Nursing ". This acresolved by 5/31/20 The facility 's QMF 11/29/2007 at 4:26 have been several structure of the age aware of who curre of Director of Nursing that the training There was no evidetime of survey to su Nursing has conducting prevent infection of the survey to surveying has conducting prevent that the training there was no evident that the training that the t | to be deficient in the area of ction control procedures to of communicable diseases. It is defined their plan of correction staff will receive additional us controls by the Director of ction was to be affective and 2007. RP was interviewed on pm and she stated that there changes in the organizational ency and that she was not ently held the title and positioning. In addition, she pointed had not been completed ence presented or on file at the distantiate that the Director of cted this training as stipulated ection. | - | W455 During the monitoring the QMRP noted that shelieve the agency em "Director of Nursing". agency employed an "Supervisor". A training conducted by the previous Supervisor who retained documentation. Such e will be obtained and mat the facility. | she did not ployed a Rather the RN swas lous RN ed the vidence aintained 12/31/07 | |
| | • | | | | continuation shee | tPage 9 n/ 9 |

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PRINTED: 12/07/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A, BUILDING B. WING 09G159 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPRUPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 1 000 INITIAL COMMENTS 1,000 A monitoring visit to the 4/13/2007 re-certification survey was conducted on 11/29/2007 to verify the facility's compliance and implementation of their Plan of Correction. Observation, staff interview and a review of the facility 's presented plans of correction revealed the provider failed to enact and enforce the necessary measures required to abate the deficiencies cited below. 1 127 3505.4(a)(5) FIRE SAFETY 1127 Each GHMRP shall have on the premises the following items: (a) Written pollcies and procedures that are approved by the Fire Chief, which shall be kept 1127 readily accessible to staff and residents and shall The evacuation route has been include the following: posted. (6) The evacuation routes; 12/31/07. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: During the monitoring visited on 11/28/2007, the facility failed to ensure that the "evacuation route(s) " was posted in the basement living area. Note: The basement houses a recreational space, a secondary bathroom, laundry facilities, and both a food and chemical storage area. There is also two separate means of egress in the basement, one in the laundry area and another in the open living space. I 180 3508.1 ADMINISTRATIVE SUPPORT 1180 Each GHMRP shall provide adequate Health Regulation Administration LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X5) DATE STAIR FORM Durp C8YS11

PRINTE.D: 12/07/2007 FORM APPROVED

If continuation sheet 2 of 5

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| | | 09G159 | | B, WING _ | | 11/2 | 9/2007 |
| IAME OF P | ROVIDER OR SUPPLIER | | 6613 6TH | DRESS, CITY. STREET, N STON, DC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | √ SHOULD 8E | (X5) COMPLE DATE |
| 1180 | needs of the reside Habilitation plans. This Statute is not The facility failed to section as identified Staff interview and revealed the facility received the proper privacy and implements. | nort to efficiently mee ints as required by the met as evidenced by ensure the provision | eir s of this 28/2007 staff esident's | l 180 | l 180 Cross-reference respon W189 on federal report | | |
| 1187 | 3508.5(d) ADMINIS Each GHMRP shall that shows the follow | • | | 1 187 | | | |
| | The facility failed to section as identified. The facility 's QMR 11/29/2007 at 4:26p have been several a structure of the age of who currently hold Director of Nursing, that the current orgaposted in the home show who currently Director of Nursing, that the current orga 08/2007. There was on file at the time of | met as evidenced by: ensure the provision | s of this at there izational ot aware on of ited out was does not sition of erified dated ited or te that | | I 187 The most recent organiz chart has been reviewed in the facility. | ation and filed 12/19/07 | |

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| AND PLAN (| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. SUILDING | | A. SUILDING | | COMPI | SURVEY LETED |
|--------------------------|--|---|---------------------|---|-----------------------------------|--------------|---------|-------|-----------------|
| | | 09G159 | , | B, WING_ | | 11/2 | 29/2007 | | |
| NAME OF P | ROYIDER OR SUPPLIER | | | | STATE, ZIP CODE | | | | |
| CARECO | | | WASHING | STREET, NO STON. DC 20 | W 0012 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENC | TION SHOULD BE THE APPROPRIATE | COMP DA | | | |
| l 187 | | _ | | l 187 | | | _ | | |
| | training as stipulated | d on the Plan of Con | rection. | | | | İ | | |
| 1 222 | 3510.3 STAFF TRA | INING | | 1222 | | | | | |
| | There shall be conti training programs so | nuous, ongoing in-se cheduled for all pers | ervice onnal, | | | | | | |
| | This Statute is not r The facility failed to section as identified | ensure the provision | r: us of this | | | | | | |
| | 1. On 4/13/2007 the state agency conducted this facility 's annual recertification and found the facility 's practices to be deficient in the area of resident privacy (W130). The provider submitted | | | | 1 222 1&2 Cross-referen | nce response | | | |
| j | tesident privacy (W1 their plan of correction QMRP would ensure further in-service train | on and indicated that the facility's smit- | ubmitted | | for W189 on feder | al report. | ļ ļ | | |
| | observing privacy by | nd on how to assist t | ا سنقم م | | | | : | | |
| | measure was to be e ensuring that the res s staff would better u | idents as well as the | facility ' | | | | | | |
| | during the state agent 1/28/2007, the OMR | ent's privacy. At 3:2 icy's monitoring vis | 23pm it on | | | | | | |
| a | PPropriate clothing (| 2007 for staff training | on " | | | | | | |
| \ \v | ressing, and groomi presently on the curre vas in attendance an | ent work schedule, o | nly two | | | | | | |
| ti | raining. There was noting of survey to substanced that its staff the scanner of the staff that its staff the scanner of the staff that its st | 10 évidence on file a | t the | | | | | | |
| , ,, | ecessary training to esident privacy. | maintain and manag | and | | | | | | |
| 2 | On 4/13/2007 the | étata + | | | | } | | | |

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| | | IDENTIFICATION NU | ER/CLIA MRER: | A, BUILDIN | IG | | |
|-----------|---|---|--|------------|---|---------------------------------|-------------------|
| NAME OF F | reporting injuries of unknown origin (W153). The provider submitted their plan of correction and indicated that "all staff have been retrained in implementing incident management procedures" on 5/10/2007. In addition, the facility further denoted that "the agency will strictly enforce its policy on holding individuals accountable, which may include termination for failure to report such occurrences." At 3:37pm during the state agency 's monitoring visit on 11/28/2007, the QMRP presented a sign—in sheet that was doad 9/11/2007 for staff training on "Incident Reporting". Of the twelve staff presently on the current work schedule, only two was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the reporting of injuries of unknown origin. 3. On 4/13/2007 the state agency conducted this facility 's santous to be deficient in the area of implementing a resident' s behavior support plan (ISSP) (W193 & W249). The provider submitted their plan of correction and indicated the following: a. For Citation #1 to address the behavioral supports for Resident #2, the facility 's response indicated that "Staff [was] trained on implementation of the BSP's for all residents on March 9 2007. A second session was scheduled for those who missad the first offering. In addition, all staff [is] trained on behavior management prior to or upon deployment into the nome. "All staff [is] trained on behavior management prior to or upon deployment into the nome. "All staff [is] trained on behavior developed for Reskilent #2. Staff will not be | 29/2007 | | | | | |
| | 0 02 | | 6613 6TH WASHING | STREET, N | W | | |
| PREFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY | 'EDUI (| PREFIX | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI | ION SHOULD BE HE APPROPRIATE | COMPLETE |
| 1222 | Continued From pa | ge 3 | | 1 222 | | | |
| | provider submitted indicated that "all simplementing incide on 5/10/2007. In addenoted that "the apolicy on holding incomy Include termina occurrences." At agency 's monitorin QMRP presented a 9/11/2007 for staff to Reporting ". Of the current work schedulattendance and sign There was no evide survey to substantia that its staff received training to maintain injuries of unknown. 3. On 4/13/2007 the | their plan of corrections their plan of corrections aff have been retrained management production, the facility furning agency will strictly endividuals accountable attention for failure to repair and the state of the 11/28/200 sign-in sheet that we training on "Incident at twelve staff present ale, only two was in need for the 9/11 training on file at the timuse that the facility end the proper and need and manage the reportion. | on and ined in cedures " ther force its e, which cort such sate 7, the as dated ing e of sured sessary orting of | | | | |
| | racility 's practices to implementing a residence (BSP) (W193 & W24 their plan of correcting following: | to be deficient in the dent's behavior sup 49). The provider su on and indicated the | area of port plan bmitted | | | | |
| | supports for Resider indicated that "Stafimplementation of the March 9 2007. A sefor those who missed addition, all staff [is] management prior to home All staff [has implementation of all | nt #2, the facility 's ref [was] trained on the BSP's for all residenced session was so the first offering. In trained on behavior or upon deployments] been retrained on the BSP's including the | ents on Cheduled In | | | , | |
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G169 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (XS) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1222 Continued From page 4 1222 assigned to support residents until they have a fundamental understanding of the BSP. This acknowledgement will be documented. " At 3:40pm during the state agency 's monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on "Behavior Support Plans". Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. There was no evidence on file at the time of survey to substantiate that the facility ensured that its staff received the proper and necessary training to maintain and manage the implementation of a resident's behavior management plan. For Citation #2 to address the behavioral supports for Resident #3, the facility 's response indicated that "Staff will receive additional training on implementing the active treatment routine for resident #3 to properly support her in managing behavior. " In addition, the facility further alleges that " the staffing patterns will be reviewed with the governing body to determine how best to support Resident #3 's [behavioral needs] " At 3:40pm during the state agency 's monitoring visit on 11/28/2007, the QMRP presented a sign-in sheet that was dated 5/22/2007 for staff training on "Behavior Support Plans ". Of the twelve staff presently on the current work schedule, only one was in attendance and signed for the 9/11 training. In addition, the QMRP was interviewed on 11/28/2007 at 3:45pm and she Indicated "that the staffing pattern(s) were not changed to address this issue, but the team decided that more training was to be the best means of addressing this resident 's needs." There was no evidence on file at the time of survey to substantiate that the facility conducted the Health Regulation Administration

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING R WING 09G159 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW **CARECO 02** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL CX41 ID PROVIDER'S PLAN OF CORRECTION ΙĎ PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY Continued From page 5 1222 1222 meeting with the governing body or ensured that its staff received the proper and necessary training to maintain and manage the implementation of a resident 's behavior management plan. 1 226 3510.5(c) STAFF TRAINING 1226 This Statute is not met as evidenced by: The facility falled to ensure the provisions of this 1226 section as identified below: Cross-reference response for On 4/13/2007 the state agency conducted this W189 on federal report. facility 's annual recertification and found the facility's practices to be deficient in the area of implementing infection control procedures to prevent the spread of communicable diseases (W455). The provider submitted their plan of correction and indicated that " staff will receive additional training on infectious controls by the Director of Nursing ". This action was to be effective and resolved by 5/31/2007. The facility 's QMRP was interviewed on 11/29/2007 at 4:25pm and she stated that there have been several changes in the organizational structure of the agency and that she is not aware of who currently holds the title and position of Director of Nursing. In addition, she pointed out that the current organizational chart that was posted in the home was not current and does not show who currently holds the title and position of Director of Nursing. That survey team verified that the current organizational chart was dated 08/2007. There was no evidence presented or on file at the time of survey to substantiate that the Director of Nursing has conducted this training as stipulated on the Plan of Correction. Health Regulation Administration

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A, BUILDING B. WING _ 09G159 11/29/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 5TH STREET, NW CARECO 02 WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 1260 Continued From page 6 1260 1.260 3512.1 RECORDKEEPING: GENERAL 1260 PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. 1260 This Statute is not met as evidenced by: Cross-reference response for The facility failed to ensure the provisions of this W189 on federal report. section as identified below-Staff interview and record review on 11/28/2007 revealed the facility failed to ensure that staff received the proper support to ensure resident's privacy and implementation of their Behavior Management Plan(s) (BMP). [Reference Licensure Citation 3510.31 1500 3523.1 RESIDENT'S RIGHTS 1500 Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this 1500 chapter, and other applicable District and federal Cross-reference response for laws. W124 on federal report. This Statute is not met as evidenced by: The facility failed to ensure the provisions of this section as identified below: On 4/13/2007 the state agency conducted this facility 's annual recertification and cited that " no system had been established to provide guardianship for consent or legally sanctioned advocacy " for Resident #3. The provider submitted their plan of correction and indicated that this deficiency would be resolved by 5/31/2007. The state agency conducted a Flealth Regulation Administration STATE FORM

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| | | 09G159 | | B. WING | | - | |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET AT | DRESS CITY S | STATE, ZIP CODE | | 29/2 007 |
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| (X4) ID PREFIX TAG | SI IMMARY STATEMENT OF THE | | ID FREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE | TON SHOULD BE | (XS) COMPI | |
| | monitoring visit on Resident #3 was st legally sanctioned a Qualified Mental Re(QMRP) was intervisit 17pm and she inc guardianship had behalf of this reside | 11/28/2007 and found fill without the service advocate. The facility stardation Profession: ewed on 11/28/2007 liceted that a requested submitted to the fit, but as of the date dian had been assign | s of any / 's al at for courts on | 1500 | | | |
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